CREDIT CARD PAYMENT AUTHORIZATION

Patient Name _____ Date of Birth _____

CREDIT/DEBIT CARD

Card Type: □ MasterCard □ Visa (We do not accept American Express)

Card Number: ___ ___ ___ ___- ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: ____/____ Security Code: _____
(Three digit code on back of card)

ACCOUNT HOLDER BILLING INFORMATION

Name (as it appears on card): _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

SIGNATURE OF CARDHOLDER: _____

Date: _____